Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: Miin Choi Journal Completion Date: 3/11/23

Setting: __X___ Acute Care _____ Outpatient _____ HHC ____ Other _____

Directions: WOC nurses function as consultants and develop plans of care for other care givers as a guide to providing care in the WOC nurse's absence. For this assignment, a mini case study has been provided. Including assessment information and the chart note. Using this information, develop a plan of care (POC) which directs care.

Do not change the information provided. The assignment should be WOC focused, and approached as both patient documentation and critical thinking development. Using a holistic WOC nursing approach combined with critical thinking strategies, complete each section of the document. Give careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care. Once you have completed the form, save the document by date and specialty. Submit to your Practicum Course dropbox for instructor review & feedback. See samples in course to assist you with this assignment.

Today's WOC specific assessment	84-year-old male with a past medical history significant for depression, hypertension, dyslipidemia, motor vehicle accident resulting in right above the knee amputation and suprapubic catheter, TIA, cataracts, and dementia. The patient was admitted to the hospital for multi-drug resistant infections both to the sacral stage IV pressure injury and ESBL in the urine. The patient is a poor historian. The patient is known to the outpatient clinic and was seen prior to admission for negative pressure wound therapy. It was noticed that the wound was stalled, malodorous, and exhibited increased drainage. The LIP obtained a culture which indicated polymicrobial growth. Around the same time frame, the patient was seen by PCP and a urine culture was taken which grew a resistant organism. The patient was admitted for IV antibiotics and wound care. This is hospital day #4. **Surgical history:** Above the knee amputation s/p MVA 2014 Suprabupic catheter s/p MVA 2014 Left knee replacement 2011 **Medications:** Vancomycin 1 Gm IV q 18 hours Unasyn IVPB 100 mg IV q 6 hours Heparin flush 20 units IV prior to discharge x 1 All other PO medications are on hold at this time (acetaminophen, lisinopril, and rosuvastatin until swallow study can be completed) **Social hx:** Smoking: never smoked ETOH: none Illicit drug use: none **Diagnostics:** Urine Culture: + E. coli, and ESBL Blood culture: negative Wound culture: +S. aureus, S.anginosus, Diphtheroids CT Pelvis w IV contrast. Report Findings: Sacral decubitus ulcer with ulceration of the underlying distal sacrum and coccyx. No evidence of focal fluid collections to suggest abscess.

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Chart note for the medical record for this patient encounter. Included is any physical assessment, interactions, and specific products that were used/recommended for use.

CWOCN-AP NOTE

Follow-up visit for suprapubic catheter care

Subjective:
ROS: unable to obtain at this time. 84 y/o male poor historian.

Objective:
T: 98.9°F, HR 70 regular, RR 18 regular, BP 138/84

General: Well nourished, well developed male, who appears stated age. No distress noted. Awake, confused, non-verbal, oriented to name only.
HENT: Normocephalic, atraumatic, moist oral mucosa, no nasal drainage, no visible lesions on external ears or nose, no oral lesions
Resp: No accessory muscle use or increased work of breathing. Respirations even and unlabored, clear to auscultation.
CVS: Heart sounds are normal with a normal apical impulse. No murmurs, gallops or rubs
PVS: right AKA, BLE warm, appropriate for ethnicity, R popliteal pulse 1+, L pedal, 2+, L popliteal pulse 1+, No edema noted
ABD: Abdomen soft and round. Active bowel sounds x 4 quadrants
GU: suprapubic urinary catheter, unsecured to skin, draining clear yellow urine.
MSK: Well-healed right AKA stump noted. No visible effusion, swelling, increased warmth, erythema, or limitation of motion of major joints.
Skin: Stage IV pressure injury to sacrum. NPWT device intact to site. PICC line right upper arm. Red rash around suprapubic catheter site, no satellite lesions.

Assessment:
Suprapubic catheter, periostomal skin breakdown
Dementia
Chronic wound, stage IV pressure injury sacrum with polymicrobial growth being managed by PCP

Plan:
Swallow study to be completed as ordered, if patient is unable to take PO intake, then referral to Pharmacy for hyperalimentation dosing.
Referral to registered dietician for dietary support.
Continue low air loss mattress and turn patient every 2 hours
Continue antibiotics per ID
Secure urinary catheter with medical adhesive tape or with a commercial device; prevent dependent loops of drainage; measure I/O every 8 hours
Local skin care to suprapubic site
Monitor the patient for fecal incontinence and diarrhea while on IV antibiotics.

Patient education:
Patient unreceptive to teaching at this time

WOC specific medical & nursing	WOC Plan of Care (include specific	Rationale (Explain why an intervention is

diagnosis and concerns	**products used)**	**chosen; purpose)**
Identify specific problems or concerns. “Risk” concerns should be incorporated into the plan for actual problems/concerns. ***NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc***	**Statements should be directive and holistic relating to the problem/concern.**	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.**
	Consult the registered dietitian.	A registered dietitian can provide a comprehensive assessment and patient education that is focused on the patient’s unique dietary needs given their medical history, wound, and current infections.
Imbalanced nutrition: less than body requirements	Notify MD if the patient is unable to tolerate PO intake per swallow study.	If the patient is unable to swallow, he may be a candidate for short-term parenteral nutrition until a long-term solution can be established.
Impaired skin integrity	Continue low air loss mattress. Turn patient Q2h.	The patient is at high risk of pressure injury due to their limited cognition, impaired mobility, poor nutrition, and high susceptibility to friction and shear forces. The low air loss mattress will enhance pressure redistribution and the patient should be turned manually.
	Secure the suprapubic catheter with medical adhesive tape or with a commercial device. Prevent dependent loops of drainage. Measure I/O every 8 hours.	The suprapubic catheter was likely leaking due to tube movement; securing the tube will prevent this. Dependent loops cause urinary stasis (increasing the risk of infection) and also increase the pressure in the catheter (allowing the urine to leak out around the tube site instead of through the tube). Measuring I&O is important to evaluate the patient’s fluid status.
	Perform local skincare to the suprapubic site daily: - Cleanse gently with normal saline and pat dry - Place one split gauze under the external bumper	Cleansing the tube site daily will prevent the accumulation of urine that is causing peristomal irritation; the split gauze can absorb any drainage from the site.
	Maintain NPWT device on sacral pressure injury. Notify the WOC team if: - NPWT becomes dislodged or malfunctions - NPWT alarm cannot be resolved per manufacturer’s troubleshooting guidelines	Wound exudate can saturate the dressing if suction is lost, increasing the risk of periwound maceration and exacerbating wound infection.
	If unable to establish suction for more than 2 hours, remove NPWT and place a temporary dressing with gauze and tape.	
Infection	Continue antibiotics per ID orders.	Diarrhea and associated transient fecal

	Monitor the patient for fecal incontinence and diarrhea while on IV antibiotics. Notify MD and WOC nurse if the patient is having persistent diarrhea.	incontinence may be due to C. difficile if the patient is on antibiotics. Depending on the extent of diarrhea, the patient may be a candidate for a fecal management system.

Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. Identify an alternative to the product. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** NPWT - Disadvantage: contraindicated for extensive infection or necrotic tissue - Alternative: for wound with high exudate - hydrofiber or alginate covered with foam dressing Medical adhesive tape or commercial adhesive tube securement device - Disadvantage: may irritate sensitive skin, may not properly stabilize the tube - Alternative: catheter securement strap

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?	My goal for this journal was to explore the care of a patient with a urinary catheter. I was able to meet my goal by being able to approach this patient's care from a holistic perspective.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My goal for the next journal is to review a WOC plan of care for a patient requiring a fecal management system.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	This journal showcased a patient case study that encompassed wound, ostomy, and continence concerns. Working through this journal solidified the value of the full-scope WOC nurse in the inpatient setting as patients admitted to the hospital are becoming increasingly complex.

Reviewed by: _____ Date: _____

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